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In the Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF FOR THE PETITIONER

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QUESTIONS PRESENTED

1. Whether general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite contrary administrative rules issued by the Secretary of Health and Human Services to govern reimbursement of particular types of costs.
2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in denying reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-14a) is reported at 996 F.2d 830. The opinion of the district court (Pet. App. 15a-37a) is reported at 796 F. Supp. 283. The decision of the Administrator of the Health Care Financing Administration (Pet. App. 40a-53a) and the decision of the Provider Reimbursement Review Board (Pet. App. 54a-84a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 18, 1993. A petition for rehearing was denied on October 4, 1993. Pet. App. 38a-39a. On December 28, 1993, Justice Stevens extended the time for filing a

(1)

petition for a writ of certiorari to and including February 1, 1994. The petition for a writ of certiorari was filed on February 1, 1994, and was granted on April 4, 1994. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

**STATUTORY AND REGULATORY PROVISIONS
INVOLVED**

1. Section 1861(v)(1)(A) of the Social Security Act, 42 U.S.C. 1395x(v)(1)(A), provides in pertinent part as follows:

The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services * * *. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific

items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. * * *

2. The regulations of the Secretary of Health and Human Services implementing 42 U.S.C. 1395x(v)(1)(A), 42 C.F.R. Pt. 413, provide in pertinent part as follows:

§ 413.9 Cost related to patient care.

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. * * *

§ 413.20 Financial data and reports.

(a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basic accounts,

as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

* * * * *

§ 413.24 Adequate cost data and cost finding.

(a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

* * * * *

(b) *Definitions —*

* * * * *

(2) *Accrual basis of accounting.* Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

3. Section 233 of the Secretary's Provider Reimbursement Manual is reprinted at Pet. App. 85a-89a.

STATEMENT

1. Medicare is a national program of health insurance for the aged and disabled. Part A of Medicare provides for the payment of inpatient hospital and related post-institutional care for the eligible individuals who are the program's "beneficiaries." 42 U.S.C. 1395e, 1395d and

1395i (1988 & Supp. IV 1992). Services are furnished under Part A by "providers of services" (e.g., hospitals), which participate by entering into a "provider agreement" with the Secretary. 42 U.S.C. 1395x(u) and 1395cc (1988 & Supp. IV 1992). The Secretary reimburses Medicare providers on an annual basis through "fiscal intermediaries." 42 U.S.C. 1395g and 1395h (1988 & Supp. IV 1992). The fiscal intermediary in this case is Community Mutual Insurance Company (Blue Cross/Blue Shield). Admin. Rec. 1032.

Respondent Guernsey Memorial Hospital is a Medicare provider. For the 1985 cost year at issue in this case, providers like respondent were reimbursed for capital-related costs on a "reasonable cost" basis.¹ The Medicare Act defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services" to beneficiaries. 42 U.S.C. 1395x(v)(1)(A). The Act authorizes the Secretary to promulgate regulations "establishing the method or methods to be used" for determining such costs. *Ibid.* The Act also directs the Secretary, in prescribing such regulations, to "consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of pay-

¹ Since October 1, 1983, most hospitals have been reimbursed for general inpatient operating costs under a system of predetermined rates known as the "prospective payment system" or "PPS." See 42 U.S.C. 1395ww(d) (1988 & Supp. IV 1992); 42 C.F.R. Pt. 412. Reimbursement for capital-related costs (like those involved in this case) continued to be made on a "reasonable cost" basis until the beginning of a transition to a "capital PPS" on October 1, 1991. The transition is scheduled to be completed by October 1, 2001. See 42 C.F.R. 412.304.

ment to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers." *Ibid.* Finally, the Act requires that provider reimbursement be specifically related to beneficiary care by mandating that only costs "necessary in the efficient delivery of needed health services" be reimbursed and that the "necessary costs of efficiently delivering covered services to [Medicare beneficiaries] * * * not be borne by individuals not so covered, and the costs with respect to individuals not so covered * * * not be borne by [the Medicare program]." 42 U.S.C. 1395x(v)(1)(A) and (i). (The latter requirement is known as the prohibition against "cross-subsidization.") The regulations that set forth general principles of reasonable cost reimbursement for Medicare purposes are codified at 42 C.F.R. Pt. 413.²

2. In 1972 and 1982, the City of Cambridge, Ohio, issued bonds on respondent's behalf to raise money for various capital improvements to respondent's facilities.³ Pet. App. 3a. The bonds were secured by mortgages on hospital property, bore interest at rates ranging from 5.25% to 12.5%, and were scheduled to mature in full by 1996 in the case of the 1972 bonds and by 2012 in the case

² The Medicare "reasonable cost" regulations were originally codified at 20 C.F.R. Pt. 405 (1967). They have been twice redesignated, first at 42 C.F.R. Pt. 405 (1977), see 42 Fed. Reg. 52,826 (1977), and most recently at 42 C.F.R. Pt. 413, see 51 Fed. Reg. 34,790 (1986). Neither redesignation affected the substance of the regulations at issue in this case. In this brief, we refer to the regulations as currently codified, giving parallel citations only where useful.

³ The 1985 refunding bonds discussed below were also issued by the City of Cambridge. See Pet. App. 56a; Admin. Rec. 440-535 (1985 trust indenture); J.A. 54, 55, 84 (bond prospectuses).

of the 1982 bonds. See *id.* at 3a, 55a-56a; J.A. 54. Outstanding bonds from the 1972 and 1982 series could also, at respondent's option, be repaid ("called") beginning in 1984 and 1992, respectively, in exchange for the payment of a "call premium" (prepayment penalty) in addition to the basic principal amount. See Pet. App. 56a; J.A. 54, 55.

The interest payments on the 1972 and 1982 bonds, as well as the costs associated with their issuance (such as underwriter's discounts and legal and accounting fees), were allowable capital-related costs for purposes of Medicare reimbursement. See, e.g., 42 C.F.R. 413.9(b)(2); 42 C.F.R. 413.130(a)(7) and (g); 42 C.F.R. 413.153. Interest costs on the bonds were incurred and reimbursed annually by Medicare each year that the bonds remained outstanding. Respondent's bond issuance costs, by contrast, were fully incurred in 1972 and 1982 (when the bonds were issued) but were not reimbursable in full in the year incurred. Instead, both for financial accounting and Medicare reimbursement purposes, the bond issuance costs were amortized as part of respondent's costs over the life of the bonds. See Pet. App. 3a-4a.

3. In 1985, the City of Cambridge issued new bonds on respondent's behalf to refinance the 1972 and 1982 bonds in an "advance refunding" or "defeasance" transaction. In that transaction, the bulk of the proceeds of the new bonds, together with certain other funds, were transferred to an irrevocable escrow account established under the control of a trustee for the purpose of paying interest on the old bonds while they remained outstanding and retiring them at the earliest possible "call" date. See Pet. App. 3a, 16a-17a.⁴ Under the terms of the old

⁴ Respondent anticipated receipt of \$15,375,000 in proceeds from the 1985 bonds. To that amount, respondent proposed to add an "equity" contribution of \$3,325,000, principally derived from

bonds, the establishment and funding of the escrow account released respondent from any further obligation to the holders of those bonds. The refinancing also eliminated certain restrictions imposed on respondent under the old bonds and freed up funds required by those bond issues for other capital purposes, including the purchase of new equipment and improvements to its facility. Admin. Rec. 191-192. Respondent estimated that the refinancing would save it approximately \$12 million in debt service costs over the remaining original terms of the 1972 and 1982 bond issues. Pet. App. 3a, 16a, 56a; Admin. Rec. 189; J.A. 17, 76.

Because the amount that respondent was required to pay into the refunding escrow account in order to defease its obligations under the 1972 and 1982 bonds exceeded the net amount at which those bonds were carried on respondent's books, respondent realized, at the time of the transaction, an accounting "loss" equal to that difference.⁵ Pet. App. 44a, 56a-57a. The parties stipulated that the amount of the accounting loss was \$672,581. J.A. 26.

various debt service and contingency funds required under the terms of the 1972 and 1982 bonds, as follows: \$325,000 from the Debt Service Fund, \$1,957,000 from the Debt Service Reserve Fund, \$355,000 from the Replacement and Improvement Fund and \$539,000 from the Contingency Reserve Fund. From these total proceeds of \$18,700,000, respondent planned to pay \$16,011,200 into the escrow fund managed by the Trustee, \$1,929,512 into a Debt Service Reserve Fund and \$759,288 in bond discount, legal, consulting and incidental costs for the 1985 bond issuance. J.A. 93. See also J.A. 97; Admin. Rec. 211-213.

⁵ For these purposes, the net carrying amount of the refunded debt consisted of the combined outstanding principal amounts of the 1972 and 1982 bonds, increased by accrued but unpaid interest, and offset by the original bond issuance costs that remained unamortized at the time of the refunding transaction. Pet. App. 57a; Admin. Rec. 196-199, 877; see J.A. 63; *Early Extinguishment*

4. a. For financial reporting purposes, respondent reflected the full amount of the refunding loss in 1985 (the year of the transaction) in accordance with "generally accepted accounting principles" (GAAP), as set out in *Early Extinguishment of Debt, Accounting Principles Board Opinion No. 26, ¶ 3(b)* (1972) (APB Opinion 26).⁶ See Pet. App. 4a; J.A. 63. Respondent also included the entire amount of the refunding loss in its Medicare cost report for that year. The "fiscal intermediary" responsible for review of respondent's cost report did not question the calculation of the refunding loss, but determined that the loss could not all be claimed in the year of the transaction. Admin. Rec. 347-357, 1038-1039. The intermediary's determination relied on a guideline

of Debt, Accounting Principles Board Opinion No. 26, ¶ 3(b) (1972). The difference between that amount and the amount that respondent paid into escrow—that is, the accounting loss recognized on the transaction—reflected not only the unamortized issuance costs, but also a call premium on the 1982 bonds (payable to holders when the bonds were called by the escrow trustee in 1992, but funded in advance by respondent's payment into the escrow account) and the difference between the interest rates payable on the refunded bonds and rates prevailing at the time of the refunding transaction (which affected the amount necessary to fund the escrow account). See Pet. App. 4a.

⁶ GAAP consists of principles established by certain "standards setting organizations" and "professional societies. Two of the "standards setting organizations" are the Financial Accounting Standards Board (FASB) and the Government Accounting Standards Board (GASB); the professional societies include the American Institute of Certified Public Accountants (AICPA). See D.R. Carmichael, S. Lilien & M. Mellman, *Accountants' Handbook* §§ 2.4(a), 2.5, 2.9 (7th ed. 1991). In the absence of an applicable formal standard from one of those organizations, what is "generally accepted" depends on "the consensus of the accounting profession" as manifested in treatises and other publications. See *ibid.*; Pet. App. 4a n.1.

contained in Section 233 of the Secretary's Provider Reimbursement Manual (PRM), an extensive set of detailed policies and guidelines issued to assist providers and intermediaries in applying the principles of reimbursement set forth in the Medicare regulations. See 1, 2 *Medicare & Medicaid Guide* (CCH) ¶ 4600-8113 (1993); App., *infra*, 1a.

Section 233 of the PRM, issued in 1983 and reprinted at Pet. App. 85a-89a, applies to "advance refunding" transactions like that undertaken by respondent in 1985. Section 233 identifies the individual expense elements of an "advance refunding" transaction and specifies when such expenses are allowable for Medicare reimbursement purposes. It provides, for example, that while incidental expenses (such as legal fees) relating to the refunding transaction are allowable as soon as paid or accrued, "call premiums" on the refunded debt are not allowable until the period in which they are in fact paid to holders of the refunded debt, and unamortized issuance costs of the refunded debt must be amortized over the period from the issuance of the refunding debt to the date that the refunded debt is actually repaid. PRM § 233.3(B)(1), (B)(3) and (C); Pet. App. 86a-87a. The overall approach of Section 233 is "to implicitly recognize any gain or loss incurred as the result of an advance refunding over [the period that the principal of the old debt remains unpaid], rather than immediately." PRM § 233.3; Pet. App. 87a.

b. Respondent appealed to the Provider Reimbursement Review Board (PRRB) (see 42 U.S.C. 1395oo(a); 42 C.F.R. 405.1835-405.1873), which reversed the fiscal intermediary's determination. Pet. App. 54a-84a. Without directly addressing the validity of PRM § 233, the PRRB held that Sections 413.20 and 413.24 of the Medicare regulations (42 C.F.R. 413.20, 413.24) required that the al-

lowance of costs for Medicare reimbursement purposes be determined according to GAAP. Pet. App. 75a-76a, 82a.

c. The Administrator of the Health Care Financing Administration reversed the PRRB's decision.⁷ Pet. App. 40a-53a. The Administrator explained (*id.* at 45a-47a; footnotes omitted):

While GAAP can be useful in determining costs related to patient care, they are not necessarily controlling. § 1861(v)(1)(A) of the Act only required the Secretary to "consider . . . the principles generally applied by national organizations;" the Secretary is not required to adopt them for determining reimbursable cost. Neither Congress nor the Secretary abdicated to the accounting profession the responsibility for determining Medicare reimbursement policy.

When evaluating whether it is appropriate to use GAAP for calculating Medicare reimbursement, one must first consider whether Medicare has a specific policy in effect. If Medicare does not, one must determine whether GAAP will identify costs that are in economic reality borne by the provider, and if so, whether the cost is properly related in time to care being rendered to Medicare beneficiaries.

The Administrator finds that for the Provider's fiscal year under review, Medicare did have a specific policy in effect governing the treatment of refunding transactions. That policy, found in § 233 of the

⁷ The decision of the Administrator is the final agency action and constitutes the decision of the Secretary. See 42 U.S.C. 1395oo(f)(1); 42 C.F.R. 405.1875.

Provider Reimbursement Manual * * * was effective for [the refinancing at issue here.]

The effect of § 233 is to require the loss on a refunding to be amortized over a number of years. This section is interpretive of 42 CFR 405.451, "Cost Related to Patient Care" [now 42 C.F.R. 413.9] which requires payments to be based on "the actual cost of services rendered to beneficiaries during the year." This policy more accurately reflects the economic reality of a bond refunding on the cost of furnishing services to Medicare beneficiaries than does APB No. 26.

The Administrator noted (Pet. App. 47a-49a):

The economic realities of the case at hand demonstrate the superiority of amortizing the loss on defeasance, rather than allowing the full cost in the year of refinancing. While the Provider's obligation on the original bond issue to repay principal of approximately \$15.6 million increased slightly with the refinancing, the overall interest obligation over the remaining term of the borrowing would decrease substantially.

* * * * *

* * * The loss was merely an adjustment to the Provider's capital structure which enabled the Provider to substitute less expensive financing for its existing more expensive financing. Thus, the loss on the refinancing did not relate exclusively to patient care services rendered in the year of the loss. The loss is more closely related to the years over which the original bond term extended (the period

over which the lower interest will be enjoyed) than to the year in which the refunding occurred.

The Administrator concluded that the policy of PRM § 233 should apply to respondent's 1985 transaction in order "to amortize the loss on the advance refunding over those periods which benefit from the reduced interest rate." Pet. App. 51a.

5. a. The district court upheld the Administrator's determination. Pet. App. 15a-37a. The court concluded that neither the Act nor the Secretary's regulations require strict adherence to GAAP for Medicare reimbursement purposes. *Id.* at 31a-32a. The court concluded that it was not arbitrary or capricious for the Secretary to depart from GAAP in this case because "the Secretary has a rational basis for concluding that, by amortizing this particular cost, he has more closely approximated the impact of the [refunding] transaction upon the provider's cost of patient care." *Id.* at 33a.

b. The court of appeals reversed. Pet. App. 1a-14a. The court acknowledged that the Medicare Act does not itself require the use of GAAP for reimbursement purposes. Instead, the Act directs the Secretary to prescribe "regulations establishing the method or methods to be used" (*id.* at 6a, quoting 42 U.S.C. 1395x(v)(1)(A)). The court noted (Pet. App. 7a), however, that the Secretary's regulations specify that "[s]tandardized * * * accounting * * * and reporting practices * * * are followed" for Medicare purposes (42 C.F.R. 413.20), that "[c]hanges in these practices and systems will *not* be required in order to determine" allowable costs (*ibid.*), and that "cost data *must* be based on * * * the accrual basis of accounting." 42 C.F.R. 413.24(a). The court interpreted these general directives to represent "a flat statement that generally accepted

accounting principles" are to be followed in Medicare reimbursement determinations. Pet. App. 6a.

The court recognized that there was "nothing irrational" about the non-GAAP treatment of advance refunding costs provided under Section 233 of the PRM, and it had "no[] doubt" that the Secretary had authority under the Medicare Act to adopt that policy. Pet. App. 8a-9a. Because the court interpreted the Secretary's general regulations to require adherence to GAAP, however, the court concluded that to follow Section 233 of the PRM would "work[] a substantive change in existing regulations" and "impermissibly change[] their meaning. Pet. App. 9a, 10a. The court therefore viewed Section 233 as a "legislative" rather than an "interpretative" rule (Pet. App. 9a) and held that it was "void by reason of the agency's failure to comply with the Administrative Procedure Act in adopting it." *Id.* at 3a. The court accordingly remanded the case for entry of summary judgment against the Secretary on the advance refunding issue.⁸

SUMMARY OF ARGUMENT

The administrative order at issue in this case requires amortized, rather than immediate, reimbursement of "advance refunding" costs for Medicare providers. That order is valid because it is not "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. 706(2)(A).

⁸ Both the district court (Pet. App. 34a-37a) and the court of appeals (*id.* at 14a) also addressed a separate issue involving the treatment of interest earned by respondent on an account established to accumulate funds for the payment of interest on the 1985 refunding bonds. Both courts ruled in favor of the Secretary on that question, and it is not at issue here.

The courts below properly acknowledged that requiring amortized, rather than immediate, reimbursement is a rational "treatment of advance refunding costs" (Pet. App. 8a) which, in light of statutory Medicare reimbursement policies, "cannot be considered arbitrary or capricious." *Id.* at 32a. The court of appeals held, however, that the Secretary had precluded such rational treatment of these costs by adopting regulations which, in the court's view, contain "a flat statement" that generally accepted accounting principles (GAAP) must be applied in adjudicating Medicare reimbursement claims. *Id.* at 6a.

That understanding of the regulations is not correct. Neither the statute nor the regulations contain such a requirement, much less a "flat statement" to that effect. By directing that claims for reimbursement be submitted under an "accrual accounting" method, the Secretary did not adopt the particular version of "accrual accounting" employed as GAAP for financial accounting purposes. The objectives of Medicare reimbursement and of financial accounting may, and in this context do, vary significantly. There is thus no "presumptive equivalency" (*Thor Power Tool Co. v. Commissioner*, 439 U.S. 522, 543 (1979)) between the two methods.

The agency's longstanding interpretation and application of the regulations confirm that no rigid GAAP requirement exists for Medicare reimbursement. Soon after the first adoption of the reimbursement regulations, the agency issued the Provider Reimbursement Manual, which contains a detailed set of policies and guidelines to assist in Medicare reimbursement determinations. The Manual recognizes that Medicare policies do not always conform to financial accounting objectives, and specifies that GAAP is to be applied only for cost situations "not covered by the

manual's guidelines and policies" (App., *infra*, 1a). The Secretary's reasonable interpretation of the agency's own regulations is entitled to "controlling weight." *Stinson v. United States*, 113 S. Ct. 1913, 1919 (1993). See also *Martin v. OSHRC*, 499 U.S. 144, 150-151 (1991).

The guideline set forth in Section 233 of the Manual specifies that amortized, rather than immediate, reimbursement of "advance refunding" costs is proper for Medicare purposes. A central issue in determining the amount of reimbursement due a provider hospital under Medicare is what costs may properly be reimbursed for *a particular cost year*. In making this annual evaluation, the Secretary must match any costs "allowed" under Medicare to services provided to the program's beneficiaries during that year. In the case of allowable costs that relate to more than one accounting year—such as, in this case, capital costs from which benefits will be derived over several years—proper periodic allocation is necessary if Medicare is to pay only that portion of the overall costs that relates to the varying use of hospital facilities by Medicare patients over the years in question. It is ultimately the responsibility of the Secretary, and not the accounting profession, to determine how legitimate costs that generate long-term benefits should be allocated among reporting periods for Medicare purposes. The Secretary's conclusion that the costs at issue here must be apportioned over several periods is entirely justified, both as a programmatic and as a factual matter, and is neither arbitrary, capricious nor an abuse of discretion. The decision of the court of appeals should therefore be reversed.

The court of appeals' basic error in interpreting the Secretary's regulations gave rise to its equally erroneous conclusion that Section 233 of the PRM "effects a

substantive change in the regulations" and is therefore a "substantive" rule that is "void by reason of the agency's failure to comply with the Administrative Procedure Act in adopting it." Pet. App. 3a. That conclusion has no force independent of the court's determination that the Manual provision, which was issued without formal notice and comment, conflicts with a GAAP accounting requirement embodied in the Secretary's regulations. As we have explained above, the regulations contain no such GAAP requirement and Section 233 of the PRM is a rational and valid interpretation of the regulations.

ARGUMENT

I. THE SECRETARY'S MEDICARE REGULATIONS DO NOT MANDATE PROVIDER REIMBURSEMENT ACCORDING TO GAAP, AND THE SECRETARY PROPERLY REQUIRED RESPONDENT'S CAPITAL-RELATED COSTS TO BE AMORTIZED

1. This case concerns the validity of an administrative order requiring amortized, rather than immediate, reimbursement of certain Medicare provider costs. The agency's order must be sustained unless it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. 706(2)(A).⁹

The court of appeals did not conclude that the Secretary's ruling now at issue in this case was arbitrary or capricious or an abuse of discretion. To the contrary, the court acknowledged that requiring amortized, rather than immediate, reimbursement is a

⁹ The provisions of chapter 7 of title 5 of the United States Code are expressly made applicable to actions by providers for judicial review of the Secretary's decision. See 42 U.S.C. 1395oo(f)(1).

rational “treatment of advance refunding costs” that the Secretary reasonably could determine “squares with economic reality.” Pet. App. 8a. The district court similarly concluded that “the Secretary has a rational basis for concluding that this particular loss should be amortized over the life of the pre-existing debt” and that the agency’s order “cannot be considered arbitrary or capricious.” *Id.* at 32a.

The court of appeals held, however, that the Secretary’s admittedly rational determination was invalid because, in the court’s view, it conflicted with “a flat statement [in the agency’s regulations] that generally accepted accounting principles” are to be followed in adjudicating Medicare reimbursement claims. Pet. App. 6a. The court of appeals thus concluded, without stating specifically, that the Secretary’s order was “not in accordance with law.” 5 U.S.C. 706(2)(A). That conclusion is not correct.

a. The court of appeals acknowledged that the Medicare provisions of the Social Security Act impose no requirement that GAAP be used for all Medicare reimbursement determinations. Pet. App. 6a. Instead, the Act explicitly assigns to the Secretary the authority to “establish[] the method or methods to be used, and the items to be included, in determining [allowable] costs.” 42 U.S.C. 1395x(v)(1)(A). It further provides that in establishing those methods the Secretary (*ibid.*):

may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on * * * costs * * *, and may provide for the use of charges or a percentage of

charges where this method reasonably reflects * * * costs.

This Court has noted the “broad authority” conferred upon the Secretary by this language to prescribe standards for reimbursement. *Good Samaritan Hosp. v. Shalala*, 113 S.Ct. 2151, 2161 n.13 (1993), quoting *Heckler v. Campbell*, 461 U.S. 458, 466 (1983), quoting *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981). Given that broad and flexible mandate to the Secretary, it is exceedingly unlikely that the Secretary would have intended, in general regulations promulgated as part of the initial implementation of the Medicare Act,¹⁰ to abdicate to the accounting profession (or to anyone else) ultimate responsibility for making particular cost reimbursement determinations. The court of appeals’ conclusion (Pet. App. 6a) that the agency’s regulations contain “what appears to be a flat statement” to that effect is thus implausible for that reason alone.

The court of appeals noted that the Act requires the Secretary, in prescribing cost-determination regulations, to “consider * * * principles generally applied by national organizations.” Pet. App. 6a, quoting 42 U.S.C. 1395x(v)(1)(A). Relying on that language, the court con-

¹⁰ The language of the relevant regulations dates from the outset of the Medicare program. See 31 Fed. Reg. 14,808, 14,810, 14,818 (1966); 20 C.F.R. 405.406(a), 405.453(a) and (b)(2) (1967). The regulations, which are now codified at 42 C.F.R. 413.20 and 413.24, were promulgated before the accounting profession adopted a GAAP standard for accounting for advance refunding transactions in 1972. See APB Opinion No. 26, ¶¶ 4-10; J.A. 64-67. Respondent’s thesis therefore must be that, while the Secretary’s method of accounting for such transactions was permissible under the regulations at the time they were issued, that method of accounting ceased to be permissible at the moment the Accounting Principles Board promulgated APB Opinion No. 26.

cluded that the Act was intended to direct the Secretary to consider the general *financial accounting* principles of "national organizations," and specifically GAAP (which the court felt that it could "safely assume" such "national organizations" would apply). Pet. App. 6a. In quoting the statute, however, the court omitted a large portion of the relevant statutory text. Section 1395x(v)(1)(A) goes on to state that the Secretary is to "consider * * * principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers." 42 U.S.C. 1395x(v)(1)(A) (emphasis added). Read as a whole, the statutory text plainly directs the Secretary to "consider" the *reimbursement* principles developed by national insurance or prepayment organizations in the health services sector. It neither explicitly nor implicitly directs the Secretary to apply GAAP *accounting* principles developed for financial reporting purposes.

The legislative history of the Act supports this understanding. During hearings on the original Medicare legislation, Social Security Commissioner Ball stated that his agency would generally "expect to follow" the "principles of payment for hospital care" set forth in a 17-page pamphlet produced by the American Hospital Association (AHA). *Medical Care for the Aged: Executive Hearings Before the House Comm. on Ways and Means*, 89th Cong., 1st Sess. 142 (1965). Later, in proposing the first set of Medicare regulations, Commissioner Ball reported that, in conformity with the statutory provision quoted by the court of appeals, he had consulted with representatives of the AHA and similar groups. 31 Fed.

Reg. 7864 (1966); see also *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 45, 59, 61-63, 197-198 (1966); *1st Annual Report on Medicare*, H.R. Doc. No. 331, 90th Cong., 2d Sess. 39-40 (1968). Neither the AHA pamphlet, nor either of the two subsidiary publications on which it relied, referred to GAAP as a guiding principle of hospital reimbursement. See American Hospital Ass'n, *Principles of Payment for Hospital Care* (Rev. Aug. 1963);¹¹ AHA, *Uniform Chart of Accounts and Definitions for Hospitals* (1959); AHA, *Cost Finding for Hospitals* (1957). The available evidence thus confirms what is in any event the natural reading of the statutory language: that the "principles * * * applied by national organizations or established prepayment organizations" that the statute requires the Secretary to "consider" have nothing specifically to do with GAAP.

An understanding of the specific objectives of financial accounting confirms the same conclusion. As this Court

¹¹ The pamphlet stated (at 6) that "[t]he determination of reimbursable cost requires acceptance and use of uniform definitions, accounting, statistics, and reporting"—a general principle similar to that eventually adopted by the Secretary in what is now 42 C.F.R. 413.20. See also Br. in Opp. 13-14. The pamphlet's explanatory comment went on to state (at 6-7), however, that "[h]ospitals must agree to provide the basic information necessary for comparable analysis of cost and equitable distribution of payments for third-party purchasers. * * * Only through uniformity of records and reports can third-party agencies be assured that they are paying for similar services in different hospitals on comparable bases." (Emphasis added). As with the regulatory language discussed below, those statements were undoubtedly directed toward the "uniformity of records and reports" required of providers, rather than toward whether particular costs are appropriate for reimbursement by the Secretary in particular periods.

has noted, financial accounting is designed "to provide useful information to management, shareholders, creditors, and others properly interested" and "has as its foundation the principle of conservatism." *Thor Power Tool Co. v. Commissioner*, 439 U.S. 522, 542 (1979).¹² The "corollary" of this principle of conservatism for financial accounting is that "possible errors in measurement [should] be in the direction of under-statement rather than overstatement of net income." *Ibid.*, quoting APB Statement No. 4, ¶ 171 (1970). Thus, expenses incurred by a business that might reasonably be amortized may,

¹² In *Thor Power Tool*, the Court considered an analogous question concerning the authority of the Commissioner of Internal Revenue to restate a taxpayer's accounts to "clearly reflect income" (26 U.S.C. 476(b)). The Court rejected the taxpayer's assertion that an accounting principle that conforms to GAAP must be presumed to be permissible for tax purposes (439 U.S. at 542-543; footnote omitted):

[T]he presumption petitioner postulates is insupportable in light of the vastly different objectives that financial and tax accounting have. The primary goal of financial accounting is to provide useful information to management, shareholders, creditors, and others properly interested; the major responsibility of the accountant is to protect these parties from being misled. The primary goal of the income tax system, in contrast, is the equitable collection of revenue; the major responsibility of the Internal Revenue Service is to protect the public fisc. Consistently with its goals and responsibilities, financial accounting has as its foundation the principle of conservatism, with its corollary that "possible errors in measurement [should] be in the direction of understatement rather than overstatement of net income and net assets." In view of the Treasury's markedly different goals and responsibilities, understatement of income is not destined to be its guiding light. Given this diversity, even contrariety, of objectives, any presumptive equivalency between tax and financial accounting would be unacceptable.

under the principle of "conservatism," nonetheless be expensed immediately for purposes of financial accounting. APB Opinion No. 26 itself represents an application of "conservatism" in financial accounting, for it accelerates the recognition of expenses that would otherwise be amortized over the remaining life of the original loan. See APB Opinion No. 26, ¶¶ 5-8; J.A. 64-66.

The purpose of Medicare reimbursement, by contrast, is to provide payment of "the necessary costs of efficiently delivering covered services to [Medicare beneficiaries]." 42 U.S.C. 1395x(v)(1)(A)(i). That purpose obviously is not identical to the objective of financial accounting. See pages 31-35 and notes 19, 20, *infra*. As a result, no "presumptive equivalency" (*Thor Power Tool Co. v. Commissioner*, 439 U.S. at 543) between Medicare reimbursement and financial accounting was embedded in the provisions of the Medicare Act.

b. The language of the regulations relied upon by the court of appeals (Pet. App. 6a-8a) provides no more support for its holding. The more detailed of those regulations specifies only that providers are to support their claims for Medicare reimbursement with "adequate cost data" based on "an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. 413.24(a). The court of appeals read the requirement that cost data be based "on the accrual basis of accounting"—rather than on cash receipts and disbursements—to entail automatic imposition, in every detail, of the *particular version* of accrual accounting embodied in GAAP. Pet. App. 7a-8a. Accrual accounting, however, is not synonymous with GAAP. See generally D. Keller, J. Bulloch & R. Shultis, *Management Accountants' Handbook* pp. 1.2-1.3 (4th ed. 1992); M. Dittenhofer, *Applying Government Accounting Principles* §§ 9.03-9.04 (1990) (discussing "accrual" and "modified accrual" accounting); Financial

Accounting Standards Board (FASB), Statement of Concepts No. 6, ¶¶ 144-149 (December 1985).¹³ Indeed, in areas where a particular GAAP standard has not been established, or where GAAP recognizes more than one approach, a variety of quite different approaches may be recognized as legitimate methods of accrual-basis accounting. See, e.g., APB Opinion 26, ¶¶ 4-10; J.A. 64-67.

The court's interpretation would be strained even if the regulation itself provided no definition of this term. In fact, however, Section 413.24(b)(2) provides a specific definition of "accrual accounting":

Accrual basis of accounting. Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected,

¹³ It is widely recognized that "[f]inancial accounting and reporting is only part of the broad field of accounting." D. Carmichael, S. Lilien & M. Mellman, *Accountants' Handbook* 3 (7th ed. 1991). Indeed, accrual accounting for state and local governments and their proprietary activities is governed by the standards of the Governmental Accounting Standards Board (GASB), which differ from the GAAP applicable to private entities relied upon by respondent here—but which in fact constitute "GAAP" for those entities to which they apply. R. Kay & D. Searfoss, *Handbook of Accounting and Auditing*, pp. 31-4 to 31-10 (2d ed. 1989); M. Dittenhofer, *Applying Government Accounting Principles* § 1.03[b][2] (1990); A. Afterman & R. Jones, *Governmental Accounting and Auditing Disclosure Manual* § 1 (1992). The GASB's Statement of Governmental Accounting Standards No. 23 requires covered entities to report gains and losses on advance refunding transactions on a deferred basis very similar to that required by the Secretary for purposes of Medicare reimbursement. See *Accounting and Financial Reporting for Refundings of Debt Reported by Proprietary Activities*, Statement of Government Accounting Standards No. 23 (Gov't Accounting Standards Bd. 1993). It should be noted that the bonds involved in this case were issued by the City of Cambridge, Ohio, on respondent's behalf. See Pet. App. 56a.

and expenses are reported in the period in which they are incurred, regardless of when they are paid.

This broad definition nowhere mentions GAAP—an organized and relatively specific set of particular accounting principles and decisions that could (and surely would) have been easily referenced had the drafters of the regulation intended to incorporate them in detail into a general requirement of accrual accounting. In any event, 42 C.F.R. 413.24 speaks only to the manner in which information must be "reported" in a provider's books, and not to the manner in which the data derived from those books will be analyzed by the Secretary (or a fiscal intermediary acting on her behalf) in determining which costs are allowable under Medicare in any given period. See pages 31-35, *infra*. Section 413.24 clearly provides only the starting point for the Secretary's reimbursement determination. It is not, as respondent claims, the ending point.¹⁴

¹⁴ Respondent argues (Br. in Opp. 17-18) that the "cost finding" language of Section 413.24 demonstrates that the references in that section to accrual accounting apply to the Secretary's reimbursement determinations, rather than simply to the manner by which the provider's records must be maintained. The "cost finding" required by the regulations refers to the process of apportioning general and indirect costs (e.g., administrative costs) to recognized cost centers for purposes of Medicare reimbursement. See generally 42 C.F.R. 413.24(d). That process merely requires the provider to reorganize some of its normal financial data in a way specifically designed to help identify which of its costs for the relevant period are allowable under the special standards of the Medicare program. The requirement that providers "recast" their basic financial data in preparing their Medicare cost reports, moreover, refutes respondent's broad assertion (Br. in Opp. 15) that Section 413.20(a) (discussed below) somehow guarantees that, in order to receive Medicare

The even more general provisions of 42 C.F.R. 413.20(a) provide equally little support for the court's analysis, although their purpose and effect are more ambiguous. Originally placed at the end of a series of essentially prefatory sections of the initial Medicare regulations (see 20 C.F.R. 405.406 (1967)), Section 413.20(a) provides:

The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

Because of its broad terms and its placement in the original set of regulations, it is unlikely that Section 413.20(a) was ever intended to do more than provide general reassurance to providers contemplating participation in the Medicare program that they would not be required fundamentally to alter their accounting practices for reporting purposes and to alert a reader to the record-keeping and cost accounting requirements set out in more detail in what later became Section

reimbursement, providers need do no more than present the Secretary with their "basic accounts, as usually maintained."

413.24.¹⁵ In any event, Section 413.20(a) by its terms does not require use of GAAP. It refers only to practices that are standard "in the hospital and related fields," suggesting if anything the use of "specially" rather than "generally" accepted principles. And, of particular relevance here, Section 413.20(a) states that the methods for determining allowable costs under Medicare "[e]ssentially * * * involve *making use of data available* from the [provider's] basic accounts, as usually maintained, to arrive at" proper reimbursement (emphasis added). There is no suggestion in this language that those methods—which "essentially" involve the "use" of data from the provider's accounts—entail rigid acceptance of the provider's own cost accounting figures (whether GAAP-based or otherwise) without further adjustment in light of the purposes and requirements of the Medicare program.

As in the case of Section 413.24, then, Section 413.20 is directed toward ensuring the existence of provider records sufficient to enable the Secretary and fiscal intermediaries to calculate the costs allowable under Medicare, not toward prescribing how that calculation will be made. Compare, e.g., 42 C.F.R. 413.53 (specifying detailed rules for apportionment of costs between Medicare and non-Medicare patients); 42 C.F.R. 413.134-413.149 (specifying allowable depreciation costs). Contrary to respondent's view, Section 413.20 (like Section 413.24) provides a starting point, rather than an ending point, for the Secretary's reimbursement determination.

¹⁵ Compare the correspondence between original Sections 405.406 and 405.453 (now 413.20 and 413.24); 405.405 and 405.454 (now 413.60 and 413.64); 405.403-405.404 and 405.452 (now 413.50 and 413.53 (Section 405.404 has no current counterpart)); and 405.402 and 405.451 (now 413.5 and 413.9).

c. This understanding of the text of the regulations is confirmed by the Secretary's longstanding interpretation and by consistent administrative practice. Soon after enactment of the Medicare Act and adoption of implementing regulations, the Secretary issued the Provider Reimbursement Manual to provide "guidelines and policies to implement Medicare regulations" and to "set forth principles for determining the reasonable cost of provider services." App., *infra*, 1a. The Manual recites (*id.* at 2a; (emphasis added)):

The procedures and methods set forth in this manual have been devised to accommodate program needs and the administrative needs of providers and their intermediaries and will assure that the reasonable cost regulations are uniformly applied nationally * * *. The manual contains informational and procedural material on various aspects of the determination of cost and to assist providers in preparing annual cost reports. * * * *For any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be applied.*

The Secretary's original and longstanding interpretation of the regulations, and the agency's consistent practice under them, has thus been that GAAP is used only as a stop-gap; GAAP is applied only for a "cost situation that is not covered by the manual's guidelines and policies." *Ibid.*) And those "guidelines and policies" are themselves designed to accommodate the specific "program needs" of Medicare's "reasonable cost regulations." *Ibid.*

The Court has consistently held that an administrative interpretation of a regulation by the agency that issued it is entitled to "controlling weight

unless it is plainly erroneous or inconsistent with the regulation." *Udall v. Tallman*, 380 U.S. 1, 16-17 (1965), quoting *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945). See *Stinson v. United States*, 113 S. Ct. 1913, 1919 (1993); *Martin v. OSHRC*, 499 U.S. 144, 150-151 (1991); *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 359 (1989); *Gardebring v. Jenkins*, 485 U.S. 415, 430 (1988); *Northern Indiana Public Serv. Co. v. Porter County Chapter of the Izaak Walton League of America, Inc.*, 423 U.S. 12, 15 (1975); *Ehlert v. United States*, 402 U.S. 99, 105 (1971). Deference is particularly appropriate when, as here, the question of interpretation arises under "a complex and highly technical regulatory program" entailing "significant expertise, and * * * the exercise of judgment grounded in policy concerns." *Pauley v. BethEnergy Mines, Inc.*, 111 S.Ct. 2524, 2534 (1991).¹⁶

The Secretary's longstanding interpretation is not irrational or inconsistent with the terms of the regula-

¹⁶ The courts of appeals have uniformly recognized that deference to the Secretary's interpretation of the regulations implementing Medicare's complex reimbursement scheme is particularly appropriate. *Butler County Memorial Hosp. v. Heckler*, 780 F.2d 352, 356 (3d Cir. 1985); *Mercy Hosp. v. Heckler*, 777 F.2d 1028, 1031 (5th Cir. 1985); *University of Cincinnati v. Heckler*, 733 F.2d 1171, 1173-1174 (6th Cir. 1984); *Abbott-Northwestern Hosp., Inc. v. Schweiker*, 698 F.2d 336, 340 (8th Cir. 1983); *Cheshire Hosp. v. New Hampshire-Vermont Hosp. Serv., Inc.*, 689 F.2d 1112, 1117 (1st Cir. 1982). See also *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 90 (1966) ("Congress [gave] * * * the Secretary very broad discretion in prescribing regulations on [Medicare] * * *, contenting itself with the statement of principles and factors by which his judgment should be guided rather than specification of rules to constrain his discretion.").

tions.¹⁷ It should therefore be upheld. See, e.g., *North Haven Board of Education v. Bell*, 456 U.S. 512, 538 n.29 (1982) (“In construing regulations, the Court normally defers to the agency’s interpretation.”); *Ford Motor Credit Co. v. Milholland*, 444 U.S. 555, 565 (1980) (agency interpretation of its own regulation upheld “[u]nless demonstrably irrational”). The court of appeals erred in failing to respect that fundamental proposition.

2. Respondent asserts (Br. in Opp. 10-11) that even if the regulations do not require use of GAAP in determining *whether* costs will be reimbursed, they do require use of GAAP with respect to the *timing* of reimbursement. The regulations provide utterly no support for that claimed distinction. They speak only of “[s]tandardized * * * accounting * * * and reporting practices” (42 C.F.R. 413.20(a)) and of “the accrual basis of accounting” (42 C.F.R. 413.24(a)). If, as respondent further claims (Br. in Opp. 15), the regulations require the Secretary to apply GAAP in making Medicare reimbursement determinations, they provide no basis for her to distinguish, in doing so, between “characterization” and “timing” issues.

¹⁷ The Secretary’s interpretation of the relationship of GAAP to her guidelines and policies is reflected not only in the Provider Reimbursement Manual (App., *infra*, 1a), but also in rulemaking proceedings concerning reimbursement rules relating to equity capital. In issuing such rules in 1976, the Social Security Commissioner explained that “generally accepted accounting principles are applicable to Medicare cost determinations *only* when a cost situation is not covered by [the regulations] *or* the *Provider Reimbursement Manual*. It is only in the absence of health insurance program policy that generally accepted accounting principles should be followed.” 41 Fed. Reg. 46,292 (1976)(emphasis added). See also *American Medical Int’l, Inc. v. Secretary of HEW*, 466 F. Supp. 605, 624 n.21 (D.D.C. 1979), aff’d, 677 F.2d 118 (D.C. Cir. 1981).

More importantly, the issue of *when* a cost relates to the provision of patient care is as fundamental to the Medicare reimbursement scheme as the determination of *whether* it relates to patient care at all. Under the “reasonable cost” system of payment, the Secretary reimburses providers on an annual basis, based upon review of the provider’s year-end “cost report.” 42 C.F.R. 413.64 During the fiscal year, the Secretary makes interim, estimated payments to providers. 42 C.F.R. 413.64(b). At the end of the year, the provider submits a detailed report, setting forth those costs for which it claims reimbursement. Based upon an evaluation of the cost report under the relevant “cost finding” and “apportionment” principles, the Secretary makes a retroactive adjustment to “determine[] the Medicare reimbursement for the actual services provided to beneficiaries during the period.” 42 C.F.R. 413.60(b) (emphasis added). See also 42 C.F.R. 413.60 (a) and (c). The regulation governing “reasonable cost” reimbursement specifically defines this retroactive adjustment as “the difference between the amount received by the provider during the year for covered services from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.” 42 C.F.R. 413.9(b)(1) (emphasis added). See generally *Good Samaritan Hosp. v. Shalala*, 113 S.Ct. at 2155-2156, 2159-2162; *Bethesda Hospital Ass’n v. Bowen*, 485 U.S. 399, 400-401 (1988). In calculating the amount of reimbursement due a Medicare provider, it is necessary to determine which costs may properly be reimbursed for that—and only that—cost year.

A central concern of “reasonable cost” reimbursement is thus that any costs “allowed” under Medicare must be

properly matched to services provided to the program's beneficiaries during the applicable period. See, e.g., 42 C.F.R. 413.24(d) (cost finding methods "to determine the actual costs of services furnished during that period"); 42 C.F.R. 413.130(c) (amortization of capital improvement costs); 42 C.F.R. 413.134-413.144 (depreciation of capital assets).¹⁸ With respect to allowable costs that relate to more than one accounting period—such as capital costs from which benefits will be derived over several periods—proper periodic allocation is necessary if Medicare is to pay only that portion of the overall costs that relate to use of hospital facilities by Medicare patients during the period in question.¹⁹

In the context of the Medicare program, it is the responsibility of the Secretary to determine how legitimate costs that generate long-term benefits should be allocated among reporting periods. *Research Medical Center v. Schweiker*, 684 F.2d 599, 602-603 (8th Cir.

¹⁸ This mandate is reflected in the statutory and regulatory prohibitions against "cross-subsidization" of costs between Medicare and non-Medicare patients. See page 5, *supra*; 42 U.S.C. 1395x(v)(1)(A)(i); 42 C.F.R. 413.5 (a), 413.9(a) and (c)(3). This principle also dates from the outset of the Medicare program. See *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 55 (1966). See also *id.* at 48, 91, 197.

¹⁹ An inappropriate shifting of costs among reporting periods could significantly affect the costs properly borne by Medicare. For example, if a provider's Medicare utilization rate (*i.e.*, the ratio of Medicare patient-days to the total number of patient-days within the facility) fluctuated significantly from period to period, or if the provider chose to withdraw entirely from the program before all benefits of a previously-incurred cost were realized, the costs appropriately borne by Medicare would be significantly altered. The Administrator noted that specific concern in his ruling in this case. See Pet. App. 49a.

1982). The Administrator explained in this case that the advance refunding loss recognized by respondent for financial reporting purposes in 1985 represented costs associated with providing health care services throughout the remaining life of the old financing arrangement and should therefore be amortized over the remaining term of the old bonds for purposes of Medicare reimbursement. Pet. App. 47a-51a. The Administrator concluded that the guidelines of PRM § 233 should be applied to this case because amortization of the refunding loss "will more accurately allocate the Provider's refinancing costs, and at the same time, more accurately reflect its current period costs." Pet. App. 51a. Moreover, "[b]y amortizing the loss to match it to Medicare utilization over the years to which it relates, the program is protected from any drop in Medicare utilization, and the provider is likewise assured that it will be adequately reimbursed if Medicare utilization increases." *Id.* at 49a. The agency's choice of amortization in this context is thus related specifically to the need properly to match reimbursement with *varying levels* of provider service over time. See note 18, *supra*. That concern, of course, played no role in development of the GAAP rule for financial accounting of advance refunding transactions in APB Opinion 26.²⁰ Cf. *Thor Power Tool Co. v. Commissioner*, 439 U.S. at 542. As the courts below both concluded, the Administrator's determination reasonably implements Medicare funding

²⁰ The discussion in APB Opinion 26, ¶¶ 5-8, of the various different methods that were "generally accepted" for financial accounting of "refunding transactions" prior to its adoption demonstrates that more than one rational, and reasonable, accrual accounting method may be applied to this issue. See J.A. 64-67.

principles and is not arbitrary or irrational. Pet. App. 8a-9a; *id.* at 32a.

The conclusion that the costs at issue are to be apportioned over the period remaining prior to repayment of the old bonds is specifically justified under the facts of this particular case. As a result of the refinancing, respondent estimates that it will save more than \$12 million in interest payments over the remaining life of the 1972 and 1982 bonds. J.A. 76; Admin. Rec. 189. The principal benefits of that reduction relate to accounting periods *subsequent* to 1985. See Pet. App. 47a-49a; J.A. 17, 76; Admin. Rec. 312. Although respondent reported this transaction as an "extraordinary loss" on its books in 1985, it did not experience an immediate, unreimbursed outflow of funds, requiring a significantly increased level of Medicare reimbursement for that year. Instead, respondent's cash requirements for the refunding were met by the proceeds of the 1985 bonds and the various debt service funds previously required under the 1972 and 1982 bonds that were released as a result of the 1985 defeasance. See J.A. 20-21 (all "out-of-pocket" costs "financed * * * from borrowing"); J.A. 93, 97. Indeed, as a result of the defeasance (and the corresponding release of funds previously required under the 1972 and 1982 bonds), respondent was able to purchase certain additional capital assets and make improvements to its facility in that year. Admin. Rec. 192, 211-213. As the Secretary concluded, the financial accounting loss experienced by respondent did not require significantly increased reimbursement but "was merely an adjustment [of its] capital structure which enabled [it] to substitute less expensive financing for its existing more expensive financing" and "did not relate exclusively to patient care

services rendered in the year of the loss." Pet. App. 48a-49a.

Both as a programmatic matter for Medicare reimbursement determinations and as a factual matter in this case, the Secretary's conclusion that respondent's "loss" on defeasance relates to more than one accounting period and requires amortization—to properly match reimbursement with varying patient service levels over time—is neither arbitrary, capricious nor an abuse of discretion. 5 U.S.C. 706(2)(A). See *Rust v. Sullivan*, 500 U.S. 173, 184 (1991); *Sullivan v. Everhart*, 494 U.S. 83, 88-89, 93-95 (1990). The court of appeals did not dispute that conclusion. Pet. App. 8a.

The court of appeals instead held the Secretary's order invalid solely because the court concluded that the concededly rational treatment of the particular costs at issue here was precluded by what the court believed to be a "flat statement" in the regulations that GAAP is to be followed in all such reimbursement determinations. Pet. App. 6a. As we have explained above, the court erred in discerning any such regulatory requirement. Because the Secretary's reimbursement determination is not "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" (5 U.S.C. 706(2)(A)), it should be sustained.

II. SECTION 233 OF THE SECRETARY'S PROVIDER REIMBURSEMENT MANUAL IS A VALID "INTERPRETATIVE" RULE OR STATEMENT OF POLICY UNDER THE APA.

1. The court of appeals' basic error in interpreting the agency's regulations gave rise to its equally erroneous conclusion that Section 233 of the PRM "effects a substantive change in the regulations" and is therefore a "substantive" rule that is "void by reason of

the agency's failure to comply with the Administrative Procedure Act in adopting it." Pet. App. 3a. As we read the court's opinion, that conclusion has no force independent of the court's determination that the Manual provision, which was issued without formal notice or comment,²¹ conflicts with what the court perceived to be a GAAP-based reimbursement requirement embodied in Sections 413.20 and 413.24 of the regulations. As we have explained above, that interpretation of the regulations is in error.

²¹ Although PRM Section 233 was issued without publication in the Federal Register, it is incorrect to claim that it was issued without any input from the Medicare provider community. Indeed, the record indicates that, in 1981, prior to issuance of PRM Section 233, the government met with representatives of the Blue Cross And Blue Shield Association, the Health Care Financial Management Association, the AICPA, the American Hospital Association, the Catholic Health Association of the United States, the Federation of American Hospitals and the accounting firm of Ernst and Whinney concerning this provision. J.A. 7-8. The agency also received comments on a proposed PRM Section 233 from the law firm of Weissberg and Aronson and the Health Care Financing Study Group (a group of investment counselors). *Ibid.* The "overwhelming" nature of the comments from the Medicare provider community was to "object[]" to GAAP treatment of advance refunding gains and losses under Medicare on the ground that the GAAP approach to that issue was overly "conservati[ve]" and "would cause distortions and a mismatching of expenses with the periods benefitted." *Ibid.* An additional concern may have been that the high interest rates of the early 1980s would have resulted in a "gain" for a provider conducting an advance refunding and that recognition of that "gain" in a single year (as GAAP requires) would have resulted in a significant reduction in Medicare reimbursement to providers. In any case, the Secretary conducted "a most intensive prior consultation"—albeit an informal one—with the Medicare provider community prior to issuance of PRM § 233. J.A. 8.

2. There is, moreover, no requirement that the Secretary develop each of the detailed policies and guidelines to be applied in Medicare reimbursement decisions by adopting substantive rules having the force of law. Nothing in the Administrative Procedure Act or in the Social Security Act requires the agency to adopt every minute and detailed reimbursement policy and guideline as a "substantive rule" with the force of law. See, e.g., *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 293 (1974); *SEC v. Chenery Corp.*, 332 U.S. 194, 202-203 (1947); 1 K. Davis & R. Pierce, Jr., *Administrative Law Treatise* § 6.8 (3d ed. 1994).²² The Secretary is free, as she has elected here, to defend a reimbursement determination issued in conformity with her informal guidelines as a rational application of the statute and existing regulations—or, in the words of 5 U.S.C. 706(2)(A), as not "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."

Because the Provider Reimbursement Manual was not issued with notice and comment and therefore does not have the force and effect of law (see *Chrysler Corp. v. Brown*, 441 U.S. 281, 301-302 (1979)), PRM Section 233 is relevant to this case only because it represents a rational interpretation of the agency's reimbursement regulations and a statement of policy as to how those regulations will be applied in the particular context of advance refunding transactions.²³ As the court stated in

¶ The impracticality of any such requirement is evidenced by the volume and variety of the issues addressed by the Manual, which is several hundred pages long and is subject to constant revision and supplementation. See App., *infra*, 1a-2a.

²² Under the APA, substantive or "legislative" rules lack legal effect if issued without prior notice and the opportunity for public comment. 5 U.S.C. 553(b) and (c). "[I]nterpretative rules" and "statements of policy," however, need not be preceded by notice

Gibson Wine Co. v. Snyder, 194 F.2d 329, 331 (D.C. Cir. 1952), “interpretative rules are statements as to what the administrative officer thinks the statute or regulation means” when applied in particular situations. See also note 23, *supra*. That description of “interpretative rules” conforms perfectly to the Secretary’s description of the Provider Reimbursement Manual as providing “guidelines and policies” for reimbursement determinations in particular fact situations. See App., *infra*, 1a. Section 233 of the Manual also could be said to be within the class of “general statements of policy” that may be issued without notice and comment (5 U.S.C. 553(b)(A)). This Court has described “general statements of policy” as “statements issued by an agency to advise the public prospectively of the manner in which the agency proposes to exercise a discretionary power.” *Lincoln v. Vigil*, 113 S. Ct. at 2034, quoting *Chrysler Corp. v. Brown*, 441 U.S. at 302 n.31.

and comment. 5 U.S.C. 553(b)(A). See, e.g., *Lincoln v. Vigil*, 113 S. Ct. 2024, 2033 (1993).

Courts have recognized that the categories of “interpretative” as opposed to “substantive” rules “have ‘fuzzy perimeters’ and establish ‘no general formula.’” *Batterton v. Marshall*, 648 F.2d 694, 702 (D.C. Cir. 1980) (footnote omitted). To make the distinction, the courts have asked whether the rule “impos[es] a new substantive obligation,” *McCown v. Secretary of HHS*, 796 F.2d 151, 157 (6th Cir. 1986), cert. denied, 479 U.S. 1037 (1987), or creates “new law, rights or duties.” *Friedrich v. Secretary of HHS*, 894 F.2d 829, 834 (6th Cir.), cert. denied, 498 U.S. 817 (1990) (quoting *General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984) (en banc), cert. denied, 471 U.S. 1074 (1985)). If so, it is substantive. Cf. *Chrysler Corp. v. Brown*, 441 U.S. 281, 301-302 & n.31 (1979); *Batterton v. Francis*, 432 U.S. 416, 425 (1977). Interpretative rules, on the other hand, “merely clarify or explain existing law or regulations.” *Seldovia Native Ass’n v. Lujan*, 904 F.2d 1335, 1347 (9th Cir. 1990).

The Secretary’s regulations already provide ample “legislative authority” for reimbursement of bond issuance costs incurred by providers and the allocation of such reimbursement to particular periods to properly match the services provided to Medicare beneficiaries during those periods. The regulations authorize reimbursement of “capital-related costs” that are “appropriate and helpful in * * * maintaining the operation of patient care facilities.” 42 C.F.R. 413.9(b)(2); see generally 42 C.F.R. 413.130-413.157. Such costs include “[n]ecessary and proper interest” and other costs associated with capital indebtedness. See 42 C.F.R. 413.130(a)(7) and (g); 42 C.F.R. 413.153(a)(1) and (b). The regulations also require that allowable costs be related to beneficiary care. 42 C.F.R. 413.5(a), 413.9; see 42 U.S.C. 1395x(v)(1)(A)(i).

The regulations do not, however, spell out how otherwise allowable bond-issuance costs, which are normally amortized over the life of the bonds to which they relate, should be treated when the liability to which they relate is removed from the provider’s books by an advance-refunding transaction. Nor do they make clear how other costs of such a refunding should be allocated among reporting periods to maintain a proper relationship to the varying levels of beneficiary care provided over time. The Provider Reimbursement Manual exists to provide detailed guidance in exactly such situations, and Section 233 provides the specific guideline applicable to the facts of this case. As the Administrator stated in this case, Section 233 is “interpretive of 42 C.F.R. 405.451, ‘Cost Related to Patient Care’ [now 42 C.F.R. 413.9] which requires payments to be based on ‘the actual cost of services rendered to beneficiaries during the year.’ Th[e] policy [of PRM § 233] more accurately reflects the economic reality of a bond refunding on the

cost of furnishing services to Medicare beneficiaries than does APB No. 26." Pet. App. 47a.

The guideline provided by PRM § 233 thus "merely * * * elaborate[s] on what is already contained in the regulations." *Homan & Crimen, Inc. v. Harris*, 626 F.2d 1201, 1210 (5th Cir. 1980). As a rational elaboration of the reimbursement regulations and the Medicare statute, PRM § 233 was validly applied by the Secretary in this case.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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MAY 1994

APPENDIX

The Foreword to the Medicare Provider Reimbursement Manual, U.S. Department of Health and Human Services, pp. I-III, states, in its entirety:

This manual provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for the Aged Act of 1965, as amended. These "Principles of Reimbursement for Provider Costs" have been published in HIRM-1. The provisions of the law and the regulations are accurately reflected in this manual, but it does not have the effect of regulations.

The Social Security Administration (SSA) also publishes quarterly the "Social Security Rulings" under the authority of the Commissioner of Social Security for the purpose of making available official rulings relating to the health insurance program and the other programs under his jurisdiction. The rulings contain appeals case decisions, as well as statements of policy and interpretations of the law (title XVIII of the Social Security Act-Medicare) and regulations which have precedential effect.

Rulings are intended to exemplify general manual instructions and do not alter existing policy guidelines. However, they may place more emphasis on a particular program area that has been identified as a problem. The rulings do not have the force and effect of a statute or regulation, but provide illustrative case material useful in interpreting and applying policies and procedures contained in instructional issuances.

(1a)

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The procedures and methods set forth in this manual have been devised to accommodate program needs and the administrative needs of providers and their intermediaries and will assure that the reasonable cost regulations are uniformly applied nationally without regard to where covered services are furnished. The manual contains informational and procedural material on various aspects of the determination of cost and to assist providers in preparing annual cost reports. The provider's intermediary will issue any necessary supplementary instructions as appropriate for local guidance on items relating to cost determination. For any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be applied.

Under generally accepted accounting principles, or under the "Principles of Reimbursement for Provider Costs" there may be more than one method for handling a particular cost item; in such case the method elected by the provider must be consistently followed in subsequent reporting periods. A change of method must be approved by the intermediary (or SSA for providers dealing directly with the Government) on a prospective and not retroactive basis. Where the manual sets a time limit for requesting such change, or limits the number of changes, the provider and intermediary will be guided by the manual instructions.

The manual accommodates new pages or revisions as further interpretations of the regulations and changes in procedures and methods are made. Accordingly, revised sections, pages, or chapters are issued as necessary. Brackets in the margin of the page indicate new or changed material.

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Questions by a provider on cost policies and procedures in the program should be referred to the provider's intermediary.